

Guidelines for Clinical Practice: From Development to Use

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"Pound together: dried wine dregs, juniper and prunes; pour beer on the mixture. Then rub the diseased part with oil and bind on. . . ." These words date from the Third Ur dynasty in Mesopotamia and predate the current guideline writing industry by about 4000 years. What is different about clinical guidelines today?

According to the Institute of Medicine, a health policy group created by the National Academy of Sciences, what are new attempts to base guidelines on the systematic analysis of scientific evidence and the recent studies of guideline implementation and effectiveness in clinical practice. Their book aims to "encourage constructive expectations for guidelines and . . . promote the kind of care and rigor in their development, application, evaluation and revision that would help such expectations to be realised." Written by committee, with contributions from a vast network of contractors and subcontractors, the text is surprisingly lucid and practical. Despite largely ignoring research on guidelines outside the United States, the authors' analysis of guideline development is applicable to the United Kingdom.

They tackle tough issues such as potentially conflicting aims of guidelines, most notoriously cost containment versus quality improvement. Even if one is on the side of the angels (that is, quality improvement), guidelines still embody choices about use of resources. The committee concludes that these choices should be explicit: every set of clinical guidelines should contain information about the costs and benefits of alternative treatment strategies, with an acknowledgment that the methods for this assessment are still in their infancy.

I appreciated the discussion of how to deal with scientific uncertainty and controversy when writing guidelines, although I am not as sanguine about "gaps" in the evidence. Where they see a landscape with lakes of uncertainty which need to be filled in, I see an ocean of uncertainty with the occasional island. Where evidence about treatment outcome is based on controlled trials in teaching hospitals I also wonder about its application to general practice.

The importance of patient education and choice in developing American guidelines contrasts with its marginal position in most British work. For the authors this aspect is as important as getting the meta-analysis right.

The most ambitious part of the book is a 40 page "instrument" for assessing practice guidelines. From my perspective of developing guidelines in east London, without the help of "research methodologists," health

economists, and consensus panels, the instrument is truly awesome. I am afraid the Hackney guidelines do not stand up to this scrutiny, although perhaps we are partly redeemed by our focus on implementation and evaluation. A guideline which fulfils all the institute's requirements is like the Holy Grail: worth striving for, but unattainable by mere mortals.—GENE FEDER, *research fellow in general practice and primary care, St Bartholomew's and the Royal London Medical College*

Whose Standards? Consumer and Professional Standards in Health Care

C Williamson
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Is the health service good for our health? Do doctors and nurses make patients better? These are questions worth considering from time to time—but how? One approach is to measure quality adjusted life years (QALYs), by assessing what people's lives are worth and then counting the length of time they can be expected to live after a particular intervention. This is a favourite among health economists.

Another approach is to investigate the health of the population as a whole. This leads to the exploration of factors beyond the health service: income, diet, environment, education. It may tend to the conclusion that doctors and nurses make very little difference. This view is not universally popular with the health professionals.



Adult oriental liver flukes (*Clonorchis sinensis*) in a biliary duct, illustrated in *Atlas of Gastrointestinal and Hepatobiliary Infections* by W E Farrar and M J Wood (New York: Gower, 1992. ISBN 1-56375-5556). The book points out that "millions of people in China and Southeast Asia are infested with this organism."

A third possibility is to set standards and measure performance. This allows for a more broadly based evaluation than the QALY but raises a wide range of questions. What shall we measure, what standards shall we have, and who shall decide? Which aspects of the professionals' behaviour have a bearing on the health of the patient? Who is fit to judge?

It is here that Charlotte Williamson enters the discussion. She begins by analysing the interests concerned: those of the patient may or may not coincide with those of the professionals. Where they don't, the professionals' interests are dominant. The patients' interests may be "oppressed" (if they know they are in conflict with the professionals, but can't do anything about it) or "suppressed" (if they are unaware of the conflict). Lobbying by health consumer groups and radical professionals can transform suppressed interests into oppressed ones, thus sharpening the debate and intensifying the campaign. Over time, this process can change the minds of the professionals about what is in their own interests, so that they begin to act more in tune with those of their patients. One example can be found in the recent history of hospital maternity units, where campaigning has led to a revolution in the treatment of mothers, fathers, and babies.

Williamson acknowledges that setting standards entails not the objective specification of inalienable truth but a continuing political negotiation between unequal power groups. She identifies autonomy as a key issue in setting standards, and argues that it is important for ethical, political, and therapeutic reasons. Patterns of treatment which promote and protect the autonomy of patients are more likely to develop a sense of wellbeing and aid recovery. This insight, if accepted, can help define standards which accord with the patients' interests.

There are few "scientific" data to prove this point, but Williamson deploys a wealth of descriptive evidence to back her claim. She argues that patients' autonomy can be enhanced by treating them with respect, by affording them ready access to supportive relatives and friends, by troubling to inform them, by giving them more control over their medication, by letting them make choices, and by including them in decisions (with the option of choosing to let others decide). Her descriptions convey an alarming jumble of bad and good practice, suggesting that whether or not a person receives autonomy-enhancing treatment is largely a matter of luck.

Synergy between professionals' and patients' interests will grow, Williamson claims, because doctors and nurses are ultimately keener to make people better than to protect their jobs and their power. We are left wondering how many of us will die of old age, if not from autonomy-diminishing treatment, before synergy triumphs over discord.—ANNA COOTE, *research fellow, Institute of Public Policy Research, London*